PLEASE DO NOT WRITE IN THIS BOX.

VIRGINIA DEPARTMENT OF SOCIAL SERVICES

2006 VIRGINIA CAREGIVERS GRANT PROGRAM APPLICATION

The Virginia Caregivers Grant Program, authorized by Senate Bill 910 (1999), provides for an annual grant to caregivers who provide assistance to a relative with a mental or physical impairment. This is a yearly grant payment up to $500, which will be paid on or before December 31, 2006, **if funds are appropriated by the General Assembly**. This application is for care that was given to a relative in the year 2005. The grant is considered taxable income by the IRS and may be used at the caregiver's discretion. Both the caregiver and the relative receiving care must meet certain eligibility criteria, and a list of those requirements is attached to this application. **APPLICATIONS ARE ACCEPTED BETWEEN FEBRUARY 1 AND MAY 1 OF EACH YEAR FOR CARE PROVIDED IN THE PRECEDING CALENDAR YEAR.** Applications postmarked prior to February 1, 2006, and after May 1, 2006, will not be considered.

INSTRUCTIONS

Completing the Application:

1. Be certain that both the caregiver and the relative meet **ALL** of the eligibility requirements. (Relevant documentation may be requested to verify eligibility.)

2. Complete sections I, II, and IV on the application. Answer all of the questions and check all of the appropriate boxes. **Do not leave any blanks.** If you do not submit the required information, or if the application is incomplete, we will be unable to approve your application.

3. A licensed physician must certify that the requirements for assistance are met. Have your physician complete section III. (You may wish to provide him or her with a copy of the attached sheet entitled "Appendix A : Definitions for Physicians" below)

4. Sign and date the application. Both your signature and the doctor's signature MUST be an original signature. According to Virginia statute, faxed, photocopied or electronic signatures will not be accepted.

5. If you have questions or need assistance completing the application, please contact your local department of social services or your local area agency on aging. You may also call the Virginia Caregivers Grant 24-hour toll-free hotline at **(877) 648-2817**. Please leave your name, area code and telephone number and someone will return your call.

Submitting the Application Package:

1. Please attach a copy of your Virginia 2005 tax return, including a copy of your W-2 form.
a. If you have not yet filed your taxes, please **do not** submit the application until your taxes have been filed.
b. If you are not required to file a tax return, please state the reason on page 2, section IV, question 4.

2. Mail the complete application package to:

Virginia Caregivers Grant Program
VDSS Adult Services Program
4th Floor, 7 North Eighth Street
Richmond, VA 23219-1849

3. Pursuant to the Code of Virginia, applications must be **postmarked between February 1 and May 1** of each year. Applications that are submitted prior **to** February 1 or **after** May 1 will not be considered.

***NOTE: Applications will not be returned to you for additions or corrections.**

SECTION I: Information in this section pertains to the CAREGIVER.

Last Name:					
First Name:		Middle Initial:		Sex:	
Street Address:					
City:		State: VA		Zip Code:	
Area Code:	Telephone:	Birth Date:			
Social Security Number:					
How many months **in the year 2005** did you care for your relative?					
What is your relationship to the relative for whom you cared? Please check one of the following boxes.					
I am the:	Husband ❑	Parent ❑	Grandparent ❑	Sister ❑	Other: (Please specify)
	Wife ❑	Child ❑	Grandchild ❑	Brother ❑	

SECTION II: Information in this section pertains to the RELATIVE receiving care.

Last Name:					
First Name:		Middle Initial:		Sex:	
Street Address:					
City:		State: VA		Zip Code:	
Area Code:	Telephone:	Birth Date			
Social Security Number:					

SECTION III: Information in this section must be provided by a PHYSICIAN

(see definitions below)

Patient's Name:				
Primary Diagnosis:				
I certify that I have assessed the above-named individual and found him/her to need assistance with the following activities of daily living (ADLs) as checked below, in accordance with the relevant state regulations (see definitions attached.)				
Bathing ❑	Dressing ❑	Bladder Continence ❑	Transferring ❑	
Toileting ❑	Eating/Feeding ❑	Bowel Continence ❑		
Physician's Printed Name:				
Physician's License #:	Physician's Telephone #:			
Physician's Signature:	Date:			

SECTION IV: This section provides certification about the accuracy of the application and the CAREGIVER'S SIGNATURE.

Please read statements (1) through (7) below, and if you agree, put a checkmark in the box next to it.

❑ (1) I certify that I provided unreimbursed (unpaid) care to my relative for at least six (6) months in the year 2005.

❑ (2) I certify that both my relative and I are residents of the Commonwealth of Virginia.

❑ (3) I certify that the relative for whom I am caring is **NOT** receiving a Medicaid-reimbursed long-term care service, except on a periodic or temporary basis as defined on the attached page. (see definitions below)

❑ (4) I certify that my adjusted gross income for the year 2005 was less than $50,000. (This refers to the **CAREGIVER'S** income.) To verify your income, please check box A or B below.

IF YOU HAVE NOT YET FILED YOUR INCOME TAX RETURN, PLEASE DO NOT SUBMIT THIS APPLICATION UNTIL A COPY OF YOUR TAX RETURN IS AVAILABLE. **IF THE TAX INFORMATION IS NOT INCLUDED, YOUR APPLICATION WILL BE INCOMPLETE AND WILL NOT BE CONSIDERED.**

A. ❑ I have attached a copy of my Virginia Income Tax form for the year 2005. (This is the form you file with the Virginia Department of Taxation, **NOT** a W-2 form.)

B. ❑ I did not file a Virginia tax return for the year 2005 and do not plan to do so.

If you checked box B above, please explain why you did not file a tax return by marking one of the four boxes below.

❑ I only receive Social Security benefits.

❑ I did not work in 2005

❑ My income was too low to file.

❑ Other: (please specify) _____

❑ (5) I understand that the decision of the Virginia Department of Social Services (VDSS) regarding this grant is final and **not open to appeal.**

❑ (6) I agree to make available to VDSS, if requested, all relevant and applicable documents used to determine whether I meet the requirements for the receipt of this grant, and I agree that VDSS may use all relevant information relating to eligibility for the requested grant. I agree that the documentation submitted cannot be returned to me and remains the property of VDSS.

❑ (7) I understand that this application must be filled out completely and accurately, or it will not be considered. I understand that an extension of time cannot be granted.

Signature of Caregiver:	Date:

Send the completed application to **VIRGINIA CAREGIVERS GRANT PROGRAM, VDSS Adult Services Program, 4th Floor, 7 North Eighth Street, Richmond, VA 23219**. If you have a question, call toll free **1-877-648-2817**.

This application must be postmarked **no earlier than February 1, 2006,** and **no later than May 1, 2006**.

Appendix A : Definitions for Physicians

(definitions for section III)

"Needs Help" means whether or not the individual needs help (equipment or human assistance) to safely perform the activity.

"**Requiring assistance,"** for the purposes of the Virginia Caregivers Grant Program, means that an individual needs at least the assistance of another person (human help only) **OR** needs at least the assistance of another person and equipment or a device (mechanical help and human help) to safely complete the activity **OR** has the activity performed for him or her.

ADL Scoring Options for Bathing, Dressing, Toileting, Transferring, and Eating/Feeding. Please see policy for additional assessment information, including scoring options for the assessment of children.

The following option does NOT meet the definition of requiring assistance.

Mechanical Help Only means the individual needs equipment or a device to complete the activity, but does not need assistance from another human **(d=semidependent)**.

Human Help Only means the individual needs help from another person, but does not need to use equipment in order to perform the activity. A need for human help exists when the individual is unable to complete an activity due to cognitive impairment, functional disability, physical health problems or safety. An unsafe situation exists when there currently is a negative consequence from not having help (e.g., falls, skin rash or breakdown, weight loss).

Supervision (Verbal Cues, Prompting). The individual is able to perform the activity without hands-on assistance of another person, but must have another person present to prompt and/or remind him or her to safely perform the complete activity. This code should only be used when the only way the activity gets completed is through this supervision.

Physical Assistance (Set-Up, Hands-On Care). Physical assistance means hands-on help by another human, including assistance with set-up of the activity.

Mechanical Help and Human Help means the individual needs equipment or a device and the assistance of another person to complete the activity **(D=Dependent).**

Performed by Others means another person completes the entire activity and the individual does not participate in the activity at all **(D=Dependent/Totally Dependent).**

Is Not Performed means that neither the individual nor another person performs the activity **(D=Dependent/Totally Dependent).**

ADL Scoring Options for Continence of Bowel

The following options do NOT meet the criteria for requiring assistance for continence of bowel.

Does Not Need Help. The individual voluntarily controls the elimination of feces **(I=Independent)**.

Appendix B: Definitions for Medicaid-Funded Long-term Care Services

(definitions for section IV- Question 4)

The following list includes, but is not limited to, services that are defined as **Medicaid-reimbursed long-term care services**. If the relative for whom you care is receiving this type of service through Medicaid, other than on a periodic or temporary basis, the caregiver is not eligible for this grant.
*(****NOTE:*** *For purposes of this document, the term* ***"periodic basis"*** *shall be defined as services received no more than twice per week. For example, a relative receiving care attends Medicaidfunded adult day care twice each week.*
Additionally, the term ***"temporary basis"*** *shall be defined as services received continuously for 30 days or less and occurring not more than once every three months. For example, a relative receiving care from a family caregiver requires Medicaid-funded personal care and rehabilitative services following a bone fracture that lasts for 3 weeks. In this case, the caregiver would continue to be eligible for the grant provided all other program criteria are met.)*

- Nursing Facility Services
- Assisted Living Facility Services
- Intermediate Care Facilities for Mentally Retarded
- Long-Stay Hospitals
- Home- and Community-Based Care Waivers (This includes the Elderly and Disabled Waiver, AIDS Waiver, Mental Retardation Waiver, Consumer-Directed Personal Attendant Services Waiver, Technology Assisted Waiver, and the Individual and Family Developmental Disabilities Support Waiver)
- Home Health Services
- Hospice Services
- Program of All-Inclusive Care for the Elderly (PACE)
- Intensive Rehabilitation Services